II. BIRTH HISTORY

Were there any problems with your pregnancy? No_____ Yes___
If YES, describe:

Type of Birth: Vaginal___ Cesarean___
Birth Weight: _____ Was this child premature? No_____ Yes___
If YES, how many weeks ?

Were there any problems at the time of birth or in the next week? No_____ Yes___
If YES, describe

Did your child come home from the hospital with you? No_____ Yes___
If NO, explain:

III. PAST MEDICAL HISTORY

1. Has your child ever been a patient in the hospital? No_____ Yes_____
If YES, list dates, hospital, reason

2. Has your child ever been to the Emergency Room? No_____ Yes_____
If YES, why?

3. Has your child ever been poisoned? No_____ Yes_____
If YES, explain

4. Has your child ever had a fever of 104F? No_____ Yes_____
If YES, explain

5. Has your child ever been seen by an eye or ear specialist? No_____ Yes_____
If YES, please explain i.e. date, specialist, type of evaluation, results.

CHILDHOOD ILLNESS	Has your child had any of the following:	No	Yes
	1. Meningitis	___	___
	2. Encephalitis	___	___
	3. Chicken Pox	___	___
	4. Scarlet Fever	___	___
	5. Rheumatic Fever	___	___
	6. Pneumonia	___	___

		No	Yes
ALLERGIES	Has your child ever had problems with any of the following:		
	1. Is your child allergic to anything? If YES, what?	___	___
	2. Eczema	___	___
	3. Drugs or Medication? If YES, what	___	___
	4. Severe reaction to insect stings? If YES, explain reaction & treatment	___	___
	5. When was your child last stung?		

SPECIAL HEALTH	1. Has your child ever had any special tests for health problems? If YES, please explain	___	___
	2. Has your child ever been seen by a specialist? If YES, please provide Name, Specialty, Date(s), Outcome for each specialist:	___	___
	3. Is your child under the care of a specialist now? If YES, please provide Name, phone number	___	___

GROWTH AND DEVELOPMENT

At what age did your child do the following?

1. Sit alone_____
2. Creep_____
3. Walk alone_____
4. Say single words_____
5. Use 2 word sentences_____
6. Become toilet trained_____

IV. PRESENT MEDICAL HISTORY

		No	Yes
GENERAL	1. Does your child have a good appetite?	___	___
	2. Does your child have excessive thirst?	___	___
	3. Does your child have sleep problems?	___	___
	4. Does your child have too much energy?	___	___

		No	Yes
GENERAL (cont)			
	5. Does your child have any physical restrictions?	___	___
	6. Does your child take any medication regularly?	___	___
	7. Does your child have trouble staying on task?	___	___
	IF YES, PLEASE EXPLAIN:		
SKIN	1. Does your child have any problems with rashes?	___	___
	2. Does your child bruise easily?	___	___
	3. Does your child get hives?	___	___
	IF YES, PLEASE EXPLAIN:		
EYES	1. Does your child have any problems with his/her eyes?	___	___
	2. Does your child's eyes turn in or out when tired?	___	___
	3. Does your child wear glasses/contacts?	___	___
	IF YES, PLEASE EXPLAIN:		
EAR, NOSE AND THROAT	1. Has your child had any ear infections or fluid in the ears? If yes, how many times?_____	___	___
	2. Does your child have trouble hearing?	___	___
	3. Does your child have frequent nosebleeds?	___	___
	4. Does your child have frequent sore throats?	___	___
	5. Does your child have frequent colds?	___	___
	6. Does your child have asthma or wheezing?	___	___
	IF YES, PLEASE EXPLAIN:		
GASTRO-INTESTINAL	1. Does your child have stomachaches?	___	___
	2. Does your child have a problem with food disagreeing with him/her?	___	___
	3. Does your child have frequent diarrhea?	___	___
	4. Does your child have trouble with constipation?	___	___
	5. Does your child vomit frequently?	___	___
	IF YES, PLEASE EXPLAIN:		
CARDIO-VASCULAR	1. Have you ever been told your child has a heart murmur?	___	___
	IF YES, PLEASE EXPLAIN:		
URINARY	1. Does your child have urinary problems?	___	___
	IF YES, PLEASE EXPLAIN:		

		No	Yes
SKELETAL	1.Does your child complain of pains in the legs, arms, back or joints?	___	___
	2. Does your child have an unusual walk?	___	___
	IF YES, PLEASE EXPLAIN:		

NEURO-MUSCULAR	1. Does your child lose his/her balance?	___	___
	2. Does your child have any unexplained movements or jerks?	___	___
	3. Has your child ever had convulsions or seizures?	___	___
	4. Does your child have any weakness in his/her body?	___	___
	5. Does your child have unusual staring spells?	___	___
	6. Does your child fall down more than most children?	___	___
	IF YES, PLEASE EXPLAIN:		

LEAD	1. Does your child chew any unusual things i.e. woodwork, pencils, crib, paint chips or plaster?	___	___
	2. Do you live in a house built before 1950 that has peeling paint on the walls, woodwork, ceiling, doors or outside of the house?	___	___
	3. Have you done major renovations in your house?	___	___
	4. Does your child seem tired, fussy, or cranky for more than 4 to 6 hours everyday?	___	___
	IF YES, PLEASE EXPLAIN:		

V. PREVIOUS EDUCATIONAL EXPERIENCE

	1. Has your child attended daycare or nursery school? If YES, please list where, days attended per week, and years attended.	___	___

VI. PSYCHOSOCIAL HISTORY		No	Yes
BEHAVIOR	Are you concerned about your child in any of the following areas. IF YES, PLEASE EXPLAIN:		
	1. Bedwetting	___	___
	2. Wetting during the day	___	___
	3. Bowels	___	___
	4. Bad dreams	___	___
	5. Biting fingernails	___	___
	6. Thumb sucking	___	___
	7. Stammering or stuttering	___	___
	8. Nervous habits of any kind	___	___
	9. Irritability, easily upset	___	___
	10. Restlessness	___	___
	11. Daydreaming, preoccupied	___	___
	12. Glum, sulky, moody	___	___
	13. Wanting too much attention, comfort or support	___	___

BEHAVIORS (cont)	No	Yes
14. Feelings are hurt easily	___	___
15. Breath holding	___	___
16. Contrary, stubborn, uncooperative	___	___
17. Selfishness, inability to share	___	___
18. Jealousy	___	___
19. Bad temper	___	___
20. Anger	___	___
21. Destroying things on purpose	___	___
22. Lying	___	___
23. Disobedience	___	___
24. Clumsiness, awkwardness	___	___
25. Difficulty separating from parent	___	___
26. Speech	___	___

IF YES, please explain speech concerns:

_____

_____

_____

Other Parent Concerns: IF YES in questions 1 through 25, PLEASE EXPLAIN:

_____

_____

_____

_____

_____

_____

_____

_____

Describe your child's strengths:

_____

_____

_____

_____

_____

_____

Dressing Skills: Please check all that apply

Independently removes	Independently puts on
___ hat	___ hat
___ shoes	___ shoes
___ socks	___ socks
___ pants	___ pants
___ pull over shirt	___ pull over shirt
___ coat/jacket/sweater	___ coat/jacket/sweater
___ mittens	___ mittens
___ unzips non-separating zipper	___ zips non-separating zipper
___ unzips separating zipper	___ zips separating zipper
___ unbuttons large buttons	___ buttons large buttons
___ pushes down underpants/pants	___ pulls up underpants/pants